DOCUMENT RESUME

ED 214 046 CG 015 780

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TITLE Psychotherapy in a Pluralistic Society.
PUB DATE Apr 81
NOTE 13p.; Paper presented at the Annual Meeting of the Western Psychological Association (61st, Los Angeles, CA, April 9-12, 1981).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Asian Americans; Case Studies; Cultural Differences; Cultural Influences; *Cultural Pluralism; Ethnic Groups; Evaluation Methods; *Hawaiians; *Minority Groups; Models; *Needs Assessment; *Psychological Needs; *Psychotherapy

ABSTRACT

A new model for psychotherapy, mandated by current evolution to a pluralistic society, is proposed in this paper. After describing the Big Island of Hawaii as a microcosm of pluralistic society, the author discusses her clinical and educational practice and explores the multi-ethnic population. An individual assessment and treatment matrix is presented, with a: (1) horizontal dimension representing a needs assessment including ethnicity, family programming, environmental pressures, physiological state, therapy history, and client's conception of the problem; (2) vertical dimension categorizing problem areas, i.e., neuroses, abuse, relationship difficulties, intellectual behavior, stress, and possible psychoses; and (3) lateral area involving treatment techniques, i.e., ventilation/support, evaluation, concept education, process education, stress education, and referral/advocacy. Implementation of the matrix is explained by actual case studies illustrating different psychotherapeutic techniques. (Author/NRB)

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PSYCHOTHERAPY IN A PLURALISTIC SOCIETY

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CG 015780

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PSYCHOTHERAPY IN A PLURALISTIC SOCIETY

In his 1980 review of psychotherapy trends, Judd Marmor, M.D., closes with a plea that patients not be tied "to a Procrustean bed of fixed technique". He says, "It is probably too much to hope that we shall some day see an end to the passionate and partisan proclamations of the superiority of one technique over all others, but it is to be hoped that the psychotherapies of the future will show increasing flexibility, combining cognitive, behavioral, and humanistic techniques with our growing knowledge of the psychophysiology and psychopharmacology of the central nervous system." (Marmor, 1980, pp. 415-416)

As a psychologist whose training has encompassed three decades, I have been personally exposed to almost all the techniques that Dr. Marmor reviews. The current evolution to a pluralistic society clearly mandates the need for a new model of psychotherapy. No longer can a therapist adopt one theoretical position and expect to find universal applications to each client.

My own life experiences as well as exposure to the rise and fall of popular theories in the dozen universities and colleges at which I have taught or been taught have enabled me to adopt a metanoid position. Ten years ago, I moved from my native California to Hawaii, where I also encountered a unique geographical perspective. During the past 2½ years, I have been working as a full-time certified psychologist in private practice on Hawaii's Big Island; I have worked with almost 300 clients as well as teaching one or two courses a year at the University.

A Microcosm of Pluralistic Society

Because of its insular quality, mixed ethnic population, increasing urbanization, employment problems, and rapid population growth, the Big Island of Hawaii can be viewed as a microcosm of a pluralistic society with its concommitant problems. The Big Island is comprised of 4038 square miles of land which includes arid desert land, snow-capped mountains, tropical rain forests, lush pastures, active volcanoes, and palm-ringed beaches. It includes almost two-thirds of the state's land area with only one-tenth of the population, which eliminates the problem of urban density, except on the Kona Coast, although it affects the availability of human service resources.

There is no majority ethnic group: Caucasians--or haoles-- and Japanese are the two largest (groups), neither of which includes more than one-third of the total population. Two more sizeable ethnic groups are the mixed Hawaiian and Filipino constituencies who range between 15-20% of the population each. Other groups who maintain their ethnic identity while each comprising less than 2% of the population are the Chinese, Koreans, Puerto Ricans,

Blacks, Indians, and Southeast Asians. The different ethnic groups tend to have stereotyped visions of one another with the expected misunderstandings in communication.

The haole group is strongly divided between the old "Kamaaina" residents, including the Portuguese, and the recent arrivals, both commercial entrepeneurs and "counter-culture" types who often exist on welfare. The Big Island represents the "last frontier", the farthest place they can "run from their problems" while still remaining warm and in the United States. Most of the population growth from 1970's 63,468 inhabitants to 1980's 92,206 persons represents mainland haole immigrants.

The absorption of almost a 45% increase in population in the last decade has been reflected in a sharp increase in social problems: minor traffic incidents increased 150%, crime offenses doubled, percentage of high school graduates decreased, illegitimate births increased from 12% to 19% of all births, and unemployment increased from 4½% to over 10%. In many ways, this island in the middle of the Pacific mirrors the problems all society is facing.

A Personal Philosophy

With diverse cultural values, multi-ethnic populations, non-traditional family groupings, and the proliferation of knowledge, flexibility and creativity become basic to survival. Alvin Toffler's 1970 landmark book, Future Shock, warned that change was avalanching upon our heads and that most people were grotesquely unprepared to cope with it. (Toffler, 1970, p. 14).

As one of only two female psychologists in private practice on the Big Island, I have had to decide whether to try to restrict my practice to some specific portion of our very heterogeneous population or try to be "all things to all people". As an eternal optimist who admires the Renaissance ideal, I opted for the latter. Because my training has encompassed developmental psychology and special education as well as the clinical field, I have sought for both commonalities in my clients as well as ways of individualizing therapeutic techniques to meet individual differences. The resurgence of interest in Jungian psychology with its Taoist emphasis upon each person being one in whom the opposite qualities are ever-present has also had a strong impact upon my thinking.

Much of my research has been in the area of sex role differences and I have been well aware of the necessity for the widest range of behavior for maximum competence, flexibility, and creativity. (Sisson, 1973; White, 1975). My other major research interest has been in neuropsychology with its emphasis upon integration of brain processes for optimal functioning: Vertical integration as discussed by Jean Ayres, Ph.D.; horizontal integration as summarized by Robert Orstein, Ph.D., and Robert Samples, Ph.D.; and Luria's emphasis upon intra-hemisphere integration as explored and discussed by

Cnarles Golden, M.D., and David Osman, Ph.D. Again, the focus has been on expanding the functional range of an individual's behavior.

Since Hawaii is a state without a clear-cut majority population and also because of its geographical location, several of the University of Hawaii at Manoa professors have done outstanding work in exploring and summarizing the field of cross-cultural psychology. In Anthony Marsella's book, Perspectives on Cross-Cultural Psychology, (Marsella, Thorp and Ciborowski, 1979), many of the papers discuss the necessity for psychotherapy "to help clients be more flexible and more aware of the alternatives beyond their present culturally-limited coping spectrum so that they can have more choices regarding adjustment". (p. 34) A paper by Paul Pedersen, Ph.D., contained in Marsella and Pedersen's most recent book, Cross-Cultural Counseling and Psychotherapy, (Marsella and Pedersen, 1981), emphasizes multi-cultural group membership as a normal and expected aspect of belonging to a complex society. Instead of a "melting pot" analogy, he feels complexity implies a pluralistic focus. Pedersen builds on Stanley Sue's earlier work and discusses the many roles a therapist must assume including outreach worker, consultant, educator, and ombudsman. The keys appear to be the therapist's flexibility in choosing techniques appropriate to the client, as well as a correct in-depth assessment of the client's needs. I will return to this individualized therapy plan with its emphasis on needs assessment after discussing those aspects of successful psychotherapy which I consider universal.

Pre-requisite Universal Values

A psychiatrist I once knew defined therapy as keeping people company through developmental or other crises. From my earlier work in educational psychology, I am cognizant that maximum learning or behavioral change results from a non-didactic interaction. Benjamin Bloom has discussed three levels of learning: Memory (rote), cognition or understanding (translating into one'e own words), and application or behavioral change. In order to be most effective, I have had to demonstrate my own values and educate or lead-out-of (from the Latin, "educare") my clients their own strengths. I have been unable to adopt the role of the expert exclusively and have had to form a partnership with each client, which implies a level of equality. Moreover, such a model has to have a preventive, educational orientation and to forego the ego-salving luxury of an authoritarian medical model. To foster a client's sense of competence, self-esteem, and self-responsibility, the therapist must become a partner in the therapeutic process.

During my second year on the Big Island, I was interviewed by the Hawaii-Tribune Herald and the editor subsequently heralded the values I rather casually espoused--respect, empathy, and responsibility--as important for the future of all citizens and nations. That was a heady experience for me and yet, on looking back, I realize how those three values I mentioned have permeated all my ideas on therapy as well as education, child-rearing, and day-to-day living experiences. (Because of this, I sometimes have difficulty categorizing what I am doing into neat little boxes.)

To me, respect for each individual implies that he or she is loveable and worthy of esteem. It is conveyed by a non-judgmental attitude which also mandates confidentiality. It is the basic unconditional regard of which Carl Rogers speaks.

Empathy also implies that I value each client and am willing to share myself as well as my training. In contrast to the traditional psychoanalytic model, I share enough of myself so that the clients have feedback that I understand the problems they face and I concretely communicate that by example or metaphor. Since so much of social learning theory has emphasized the importance of modeling behavior, sharing my own abilities and liabilities can be a powerful therapeutic agent.

The third value, Responsibility, places limits on the support I convey. Rosenthal has provided much evidence on the value of expectancy in enhancing individual growth. I must view each client as capable and competent. I will also provide information and assist in the detailing and organizing of alternatives and their consequences. I also must differentiate between changeable and unchangeable situations and accept the responsibility for not neutralizing a client's energy by excessive support when he or she is faced with an abusive situation which should be changed in order for the client to survive and grow. I must also be responsible and accountable in evaluating the effectiveness of therapy for any particular client. This implies the assessment of the client's needs and the detailing of an individual plan mentioned earlier.

An Individual Assessment and Treatment Model

Marsella offers a research matrix for investigating cause, problem, and treatment interactions which I have adopted for my clients: the first section, the horizontal dimension, is a needs assessment. Because so many of my clients are from less verbal cultures which don't reinforce openness in discussing personal problems, I have adopted a question and answer format. I first became aware of what I was doing when I watched an excellent legal aide para-professional obtain a great deal of information in an informal manner. The format is characterized by three things: acceptance of whatever is said, occasional brief "talk story" periods where personal or other empathic statements are offered, and a following of the client's lead with questions interjected as necessary. The information I am interested in eliciting is:

1. Ethnic background of self, partners, and parents.
2. Familial programming, including birth order, siblings, and stability of parental relationships.
3. Current environmental pressures including geographical location, relationships, financial constraints, employment status, and internal and extended family problems.
4. Physiological state, including use of prescribed medication and "street" drugs.

5. Preconceptions and previous experiences with therapy.
6. The areas in which the client thinks problems exist.

The vertical dimension of the matrix is a categorizing of problem areas and is primarily for clarifying my thinking as well as insuring I am considering a broad spectrum of potential problems. Most of my clients fall into the following areas which tend to overlap the old D.S.M. II classifications.

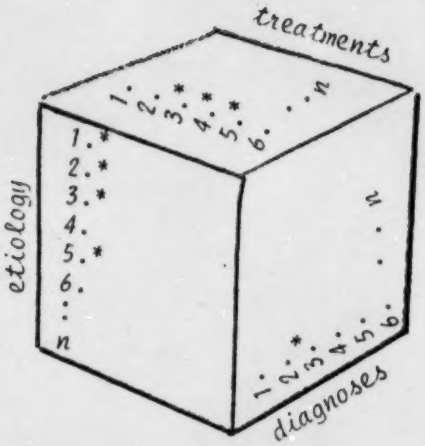
1. Neuroses -- depression, anxiety, phobias, etc. (referred by physicians).
2. Abuse -- spouse, sexual, incestual, societal, substance (most of these involve personality disorders and are referred by social service agencies).
3. Marital/relationship problems including divorce, custody and regrouping. (These usually involve situational disturbances and are often referred by attorneys.)
4. Intellectual behavior -- retardation, learning disabilities, gifted adjustment problems, immature and inadequate developmental problems. (These referrals come from parents and educators after consultation with physicians.)
5. Stress -- including psychophysiological interactions (physician referred).
6. Psychoses -- manic/depressive and schizophrenia. (Most of these are treated by psychiatrists but occasionally a client who has been seen on another basis will develop a psychosis; additionally, the courts assign occasional evaluations.)

The lateral area of the matrix involves treatment techniques which I have summarized under six categories but which obviously may increase 1...n. One difference between this categorization and many others is my bias towards the use of educational techniques. To me, working in a community facilitating mental health implies both therapeutic and preventive educational work. The general treatment areas are:

1. Facilitation of ventilation and development of support systems -- both individuals and groups.
2. Evaluation of intellectual, vocational, educational-achievement and personality traits; all clinical evaluation is also used as treatment in helping the client understand self.
3. Education about psychodynamic and developmental concepts as well as sharing of resources such as books and tapes. Education is not a didactic process but involves experiences to be integrated into the person.
4. Education about processes such as decision-making and communication techniques. Here again , the emphasis is on activities such as role playing.
5. Education about techniques for reducing and preventing stress -- relaxation, biofeedback, self hypnosis.
6. Referral to and advocacy with other agencies and persons.

Case Examples and Adaptations

I will conclude by sharing several case histories and give examples of how I have adapted techniques to meet individual needs within a pluralistic context.



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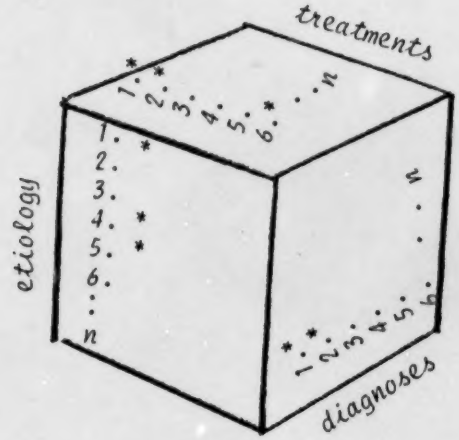

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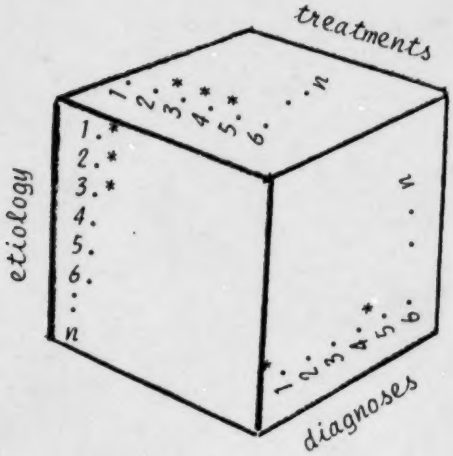

(C)

Individual Treatment Plan (ITP) Model

The first case (A) typifies problems faced by both non-traditional family groups and multi-ethnic relationships. Betsy is a young haole woman from the Mainland with a six year old daughter. She met George, a mixed Hawaiian male while she was on vacation and married him two years ago. According to a book published by the University of Hawaii Medical School (McDermott and Fukunaga, 1977) intercultural marriages amount to 50% of the marriages in the state and 20 million U.S. families (Visher & Visher, 1979), involve step children. McDermott and Fukunaga emphasize that intercultural marriages are much like step-families because each partner carries a divergent history with both hidden and open expectations and values which continue to influence each partner.

In this case, the needs assessment and an uncovering of concepts unconsciously learned about the roles of husbands and wives during developmental years was extremely important; sharing information about potential pitfalls and translating psychodynamic concepts into non-academic language was also very valuable for Betsy and George as a means of enhancing communication between the partners. After the first rosy glow of romance has dissipated, the family must expend an extraordinary amount of energy building the relationship when one is bridging cultural and ethnic differences.

In this case, I used three techniques: one was an exercise from a book, I Need to Have You Know Me, which focused on development of values from each of the partners' parents. The second was a revision I have made of a questionaire from Lederer and Jackson's classic book, The Mirages of Marriage. The questions are changed so that they do not assume that the partners are married; the role expectations are equalitarian, (i.e., no assumptions are made that the man works and the woman stays home). The third technique was developed from my own experience in re-grouping my family and is a list of ten guidelines to try to prevent problems in step-families. The techniques were useful and communication was enhanced between Betsy and George. They have strengthened their marriage and are now expecting another child.

A second case (B) I would like to share with you involves a young Filipino-Hawaiian woman, Roseanne, who was in an abusive relationship with her Filipino boyfriend, Rogerio. They have a three year old son, Roger-boy. She was referred to me by Child Protective Services because they were concerned about potential child abuse on the part of the parents.

I have learned to ask clients, (particularly when they have not been raised by their natural parents), "when you were little, did your 'uncle' fool around with you much?" In Roseanne's case, it uncovered a history of being "used" by the males of the family for many years. It also helped explain her easy acceptance of abuse in her adult relationship.

In many local families, particularly if their cultural ideas are somewhat primitive, children, especially female ones, are possessions. When Roseanne was a child if her stepfather had been drinking and was angry, his anger was vented on those persons smaller and less important than himself, a wife and/or children. And if Roseanne cried at a "dirty lickin", she was consoled with sexual caresses and candy. The little girl accepted it as her lot in life, particularly since her mother had learned to escape the house when her husband came home from drinking.

In many ways, the psychodynamics of Roseanne's incestual relationships must be interpreted as having developed because of lack of explicit inhibitions, exacerbated by the concept of children as property, "things" with which to amuse oneself. Roseanne, as a victim, grew to adulthood with a ready acceptance of her position as one in which she expected to be abused. When anger did develop, it often became misdirected towards her child and the cycle continued.

Breaking the cycle for Roseanne involved developing support groups, new "ohana" networks. Often mixing women from different cultural and ethnic backgrounds is helpful because of the different perspectives and insights each brings; more vocal women offer models for their more taciturn sisters, helping them express their feelings verbally. Other useful techniques involved advocacy with social service agencies to provide respite from her young child through a pre-school program, as well as sharing books and informative articles in our island community which is isolated from the media flow which inundates most of the United States. Roseanne has not yet separated from Rogerio but she will not permit physical abuse and goes to the Family Crisis Shelter if he threatens her. She says he has agreed to participate in a men's group they are sponsoring.

Mieko (C) is another case which exemplifies the need for the therapist to adapt to ethnic expectations and use a variety of techniques. Mieko is a Japanese civil servant in her 40's referred by her physician for anxiety and depression. She complained of alternating between periods of apathy where she couldn't face getting out of bed and highly anxious moments in which her heart raced and she had a lump in her throat. Finally, she complained of being unable to communicate with her new co-workers. In an effort to satisfy equal employment opportunity standards, the traditional all-Japanese department had been shifted and her working team now consisted of a Mainland haole man and a young local Portuguese woman.

Treatment for Mieko consisted of directed relaxation with galvanic skin response biofeedback and autogenic relaxation tapes to play at home. Very slowly,after becoming comfortable talking about physical problems, Mieko was encouraged to discuss her personal relationships. An individualized assertiveness training program was instituted, using the book, Effectiveness Training for Women, because it emphasized moving from assertiveness to empathic listening and back. This was acceptable from a cultural standpoint since it also focused on others' feelings. She did not wish to change her traditional submissive role with her spouse and her wishes were respected. However, she was encouraged to verbalize her feelings regarding the inequities she sometimes felt.

Since she felt comfortable being more assertive with her co-workers, she was encouraged to role-play situations concerning them. I also shared an ethnic values test which had been developed as both a spoof and a means of becoming aware of how seldom does any one individual meet a stereotyped conception of ethnic identity. Gradually, as she practiced relaxation,

vented her frustrations, realized common values she shared with her co-workers, and developed more control over her work life through successful assertive experiences, Mieko's depression lessened. She no longer uses medication and is coping well at work and home, feeling positive about herself and her life.

Conclusion

In 1851, 130 years ago, a New England psychiatrist said, "Insanity is then part of the price we pay for civilization. The causes of the one increase with the developments and results of the other." (p. 35, Marsella, et al, 1979). Hopefully, this sad indictment may be alleviated in our current complex society through an individualized psycho-educational and therapeutic partnership which demonstrates mutual respect, empathy, and responsibility between client and therapist.

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